Exhibit A

CALLAGY LAW, P.C.
A Limited Liability Company
Lori B. Shlionsky (Bar Id. 205322017)
Mack-Cali Centre II
650 From Road, Suite 240
Paramus, New Jersey 07652
Phone: (201) 261-1700
Fax: (201) 549-6236
E-mail: lshlionsky@callagylaw.com
Attorneys for Plaintiff, Metropolitan Neurosurgery Associates

METROPOLITAN NEUROSURGERY ASSOCIATES on assignment of GREGG M.,	:	**SUPERIOR COURT OF NEW JERSEY LAW DIVISION: SPECIAL CIVIL PART**
Plaintiff,	:	**BERGEN COUNTY**
v.	:	**DOCKET NO.:**
CIGNA HEALTH AND LIFE INSURANCE COMPANY,	:	**CIVIL ACTION**
Defendants.	:	**COMPLAINT**

METROPOLITAN NEUROSURGERY ASSOCIATES on assignment of GREGG M. by way of Complaint against CIGNA HEALTH AND LIFE INSURANCE CARE ("Defendant(s)"), asserts:

THE PARTIES

1. For all relevant times herein, Plaintiff is and was a healthcare provider in the State of New Jersey whose principal place of business is 309 Engle Street, Englewood, New Jersey 07631.

2. Upon information and belief, Defendants were present and engaged in significant activities in the State of New Jersey to sustain this Court's exercise of in personam jurisdiction.

3. Venue and Jurisdiction is proper in the Bergen County Superior Court because the Plaintiff resides in Bergen County.

ANATOMY OF THE CLAIM

1. Upon information and belief, at all material times Principal had health insurance through his employer, Smart Source Rentals which provided health insurance benefits via a group insurance contract administered by third-party Cigna Life Insurance Company.

2. At the time of the subject surgery Principal's selected medical benefit option was the Open Access Plus plan. See **Exhibit A**.

3. Patient presented to Englewood Hospital and Medical Center located at 350 Engle Street, Englewood, New Jersey 07631 on 09/17/2018, with severe disc herniation at C5-C6. See **Exhibit B**.

4. On 09/17/2018, Drs. Yakov Gologorsky and Kevin Yao, medical providers with Metropolitan Neurosurgery Associates, provided medically necessary and reasonable services to Patient. Id.

5. Patient underwent an anterior cervical discectomy at C5-C6 along with a fusion and allograft on 09/17/2018. Id.

8. At the time of the subject surgical procedure, Metropolitan Neurosurgery Associates was not participating in the network of providers associated with the benefits provided by the plan. See **Exhibit C**.

10. The bill for this service, submitted to Defendant by way of health insurance claim forms ("HICFs"), was $73,680.00. See **Exhibit D**.

11. On April 22, 2021, Defendants denied the claims in their entirety for lack of prior authorization. See **Exhibit C**.

12. Prior to the scheduled procedure, Plaintiff sought and obtained pre-approval to perform the subject surgery on August 13, 2018. See **Exhibit E**.

13. Specifically, on May 25, 2018, Defendant sent prior authorization paperwork to the patient directly which indicates CPT codes 22551, 22853, 20939, and 22845 were approved. Id.

14. The surgery was later rescheduled to September 17, 2018, Plaintiff again contacted the Defendant seeking pre-approval and to notify the Defendant of the newly schedule procedure date. See **Exhibit F**.

15. On June 26, 20218, Plaintiff called Defendant and spoke with a representative by the name of Rich E. regarding the change in date of the surgery, in turn, a new authorization number of IP0184100726 was issued. Except for the change in the date of service, no other modifications were requested or made. Id.

16. After the subject surgical procedure was performed, Defendant advised Plaintiff that the pre-approval for the September 17, 2018 date of service was only for CPT code 22845 as opposed to all of the codes and declined to adhere to its original pre-approval. As such, Defendant incorrectly denied CPTs 22551, 20939, 22853, 22551-82 and 22853-82See **Exhibit E**.

17. This represents an underpayment of approximately $13,404.75, considering applicable pay rates and reductions, which is 300% of the CMS allowable rate according to Defendant's agent, Marna Berman during the insurance verification process.

18. The amount in dispute in this matter concerns the appropriate level of reimbursement for out-of-network services for the improper denial of pre-authorized benefits. See **Exhibit E**.

19. Metropolitan Neurosurgery Associates appealed Defendant's determination on multiple occasions.

20. Upon information and belief, Plaintiff has exhausted all administrative remedies.

21. Metropolitan Neurosurgery Associates, proceeding on an Assignment of Benefits from Patient, brought suit. See **Exhibit G**.

22. Accordingly, Plaintiff brings this action for the recovery of the balance of benefits due to Principal under the Plan for the treatment rendered to him by the providers within Metropolitan Neurosurgery Associates.

FIRST CAUSE OF ACTION

(Breach of Contract)

1. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

2. As a result of the foregoing, Defendants provide health insurance benefits to the insured Patient and through their actions breached the contract with the Patient.

3. As a result of Defendants actions, Plaintiff has been damaged in an amount of $13,404.75 for date of service 09/17/2018, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

SECOND CAUSE OF ACTION

(Unjust Enrichment)

4. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

5. Defendant was unjustly enriched at the expense of the Plaintiff.

6. Plaintiff provided services to Patient, the Defendants insured, and the Plaintiff was underpaid pursuant to the health benefit plan.

7. As a direct and proximate result of the Defendant's actions and unjust enrichment, Plaintiff has suffered, and will continue to suffer, substantial monetary damages.

8. As a result of Defendants actions, Plaintiff has been damaged in an amount of $13,404.75 for date of service 09/17/2018, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

THIRD CAUSE OF ACTION

(Promissory Estoppel)

9. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

10. Defendant made representations to Plaintiff concerning payment in accordance with the health benefit plan or Summary Plan Description ("SPD").

11. Defendant failed to comply with the terms of the Summary Plan Description.

12. Plaintiff reasonably relied upon the representations made by the SPD.

13. As a result of Defendants actions, Plaintiff has been damaged in an amount of $13,404.75 for date of service 09/17/2018, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

FOURTH CAUSE OF ACTION

(Breach of Duty of Good Faith and Fair Dealing)

14. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

15. Defendants owed Plaintiff an obligation to act in good faith and deal fairly with him regarding the terms of the SPD.

16. By engaging in the misconduct alleged herein, Defendants breached their duty of good faith and fair dealing, which has damaged and continues to damage Plaintiff.

17. As a result of Defendants actions, Plaintiff has been damaged in an amount of $13,404.75 for date of service 09/17/2018, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

WHEREFORE, Plaintiff demands judgment against Defendants, as follows:

a. For an Order directing Defendant to pay to Plaintiff $13,404.75 for date of service 09/17/2018;

b. For compensatory damages and interest;

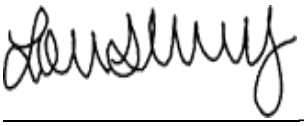
c. For attorney's fees and costs of suit, if allowed by the Agreement; and

d. For such other and further relief as the court may deem just and equitable.

[Signature block continued on next page.]

Dated: February 8, 2024

Respectfully,
CALLAGY LAW, PC



Lori B. Shlionsky (Bar Id. 205322017)
650 From Road, Suite 240
Paramus, New Jersey 07652
Telephone: (201) 261-1700
Facsimile: (201) 549-6237
E-mail: lshlionsky@callagylaw.com
Attorney for Plaintiff

TRIAL COUNSEL DESIGNATION

Lori Shlionsky, Esq., is hereby designated as Trial Counsel in the above matter.

R. 4:5-1(b)(2) CERTIFICATION

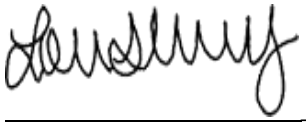
Pursuant to R. 4:5-1(b)(2), I hereby certify that the matter in controversy is not the subject of any other action pending in any court, is not the subject of a pending arbitration proceeding and is not the subject of any other contemplated action or arbitration proceeding, except as may be set forth below:

None.

I further certify that I know of no non-parties who should be joined in the action pursuant to R. 4:28, or who may be subject to joinder pursuant to R. 4:29-1(b) because of potential liability to any party on the basis of the same transactional facts, except as may be set forth below:

None.

Respectfully,
CALLAGY LAW, PC



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Facsimile: (201) 549-6237
E-mail: lshlionsky@callagylaw.com
Attorney for Plaintiff

EXHIBIT “A”

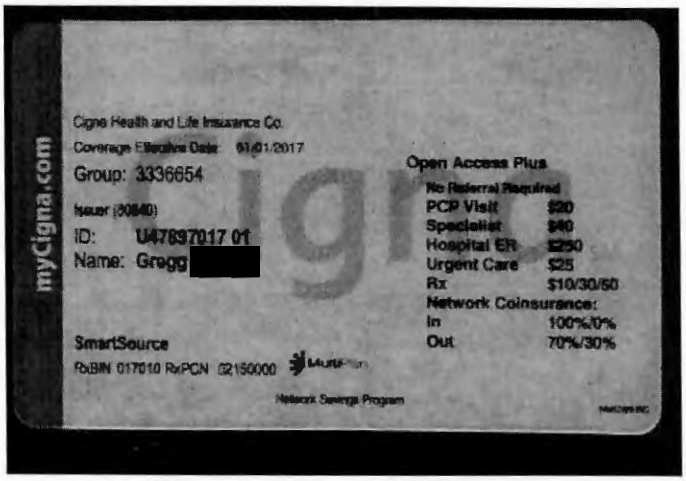
mycigna.com
Cigna Health and Life Insurance Co.
Coverage Effective Date: 01/01/2017
Group: 3336654
Issuer (30840)
ID: U47897017 01
Name: Gregg [redacted]
SmartSource
RxBIN 017010 RxPCN 02150000
Network Savings Program
Open Access Plus
No Referral Required
PCP Visit $20
Specialist $40
Hospital ER $250
Urgent Care $25
Rx $10/30/50
Network Coinsurance:
In 100%/0%
Out 70%/30%

EXHIBIT “B”

[redacted], Gregg

MRN: 00779632
Description: 47 year old male

Operative Report Date of Service: 9/17/2018 11:28 AM

Yakov Gologorsky, MD
Neurosurgery

ENGLEWOOD HOSPITAL and MEDICAL CENTER
350 Engle Street
Englewood, NJ 07631

REPORT OF OPERATION

NAME: Masse, Gregg
SURGEON: Yakov Gologorsky, MD
MRN: 00779632
ACCOUNT NO: 4006057344

DATE OF PROCEDURE: 09/17/2018.

ASSISTANT: Kevin Yao, M.D.

PREOPERATIVE DIAGNOSES: C5-C6 disc herniation.

POSTOPERATIVE DIAGNOSES: C5-C6 disc herniation.

PROCEDURE PERFORMED:
1. Anterior cervical discectomy C5-C6.
2. Anterior cervical intravertebral fusion with allograft and morselized autograft C5-C6.
3. Placement of Globus Coalition cage C5-C6.
4. Anterior cervical instrumentation C5-C6.
5. Bone marrow aspiration C6 vertebral body.
6. Use and interpretation of fluoroscopic images.
7. Use of operative microscope with increased illumination and magnification for microdissection.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Minimal.
INTRAVENOUS FLUIDS: 800.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room where general endotracheal anesthesia was induced. Preoperative antibiotics and steroids were administered. All IV lines were placed.

Baseline neuromonitoring potentials were obtained.

The patient was subsequently positioned with a shoulder roll slightly extending the cervical spine. A natural skin crease was chosen, which was found to be overlying the

C5-C6 intravertebral disk space on crosstable fluoroscopy. An incision was marked out in the midline and coursing towards the right side approximately 3 cm in that skin crease. This entire area was prepped and draped in the usual sterile manner and a surgical timeout was then taken.

A #15 blade was used to incise the skin. Dissection was carried with Bovie cautery through the subcutaneous tissues and platysma, which was undermined in all directions. An avascular plane was subsequently developed with the trachea, esophagus and strap muscles medially, and the carotid sheath and the sternocleidomastoid laterally. This was followed until the anterior cervical spine was identified. The longus colli muscles were immobilized bilaterally and self-retaining retractors were placed. The fluoroscope was used to confirm appropriate level.

A 15 blade knife was used to create annulotomy. This material was removed. The overlying lip of C5 was removed with the Kerrison rongeur and saved for later use as autograft. Caspar distraction pins were placed at C5 and C6. Bone marrow was aspirated from the C6 vertebral body and mixed with allograft.

At this point the operative microscope was brought in to increase illumination, magnification, and for microdissection.

The remainder of the disc space was evacuated of disc material. The endplates were prepared for fusion using rasping curettes. The posterior longitudinal ligament was opened sharply and the dura was decompressed widely from joint of Luschka to joint of Luschka, bilaterally.

Varying size trials were used until an appropriate size Globus Coalition cage was chosen. The cage itself was packed with allograft and morselized autograft and inserted into the C5-C6 intervertebral disc space. Anterior cervical instrumentation was passed into the C5 and C6 vertebral bodies and tightened according to the manufacturer's guidelines.

Biomechanical and visual inspection demonstrated excellent fixation. Somatosensory evoked potentials and motor evoked potentials remained stable. EMG activity remained quiet. Fluoroscopic images demonstrated excellent position of all instrumentation.

The wound was copiously irrigated and hemostasis was meticulously achieved. 3-0 Vicryl sutures were used to approximate the platysma layer, a running 4-0 Monocryl was used for the subcuticular layer and Dermabond was applied. A dry sterile dressing was placed.

All counts were correct at the end of the procedure.

Yakov Gologorsky, MD

Dict: 09/17/2018 11:12:41 AM
Trans: 09/17/2018 12:28:53 PM
Job#: 178719318
PMC: cw

CC: Yakov Gologorsky, MD

Admission
(Discharged) on
9/17/2018

EXHIBIT “C”

Provider Explanation of Medical Benefits Report Cigna.

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL	Page
222478733 0029	METROPOLITAN NEUROSURGER	10/10/2018	Retain for Your Records	1

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

PATIENT NAME: GREGG [redacted]E PATIENT#: C6900071 OPERATION LOCATION/GROUP# 53496-9-5534654 RECEIVE DATE: 09/24/2018 PROCESS DATE: 10/10-
PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER PROVIDER NETWORK STATUS: OUT OF NETWORK
SUBSCRIBER NAME: GREGG M[redacted] SUBSCRIBER#: U47897017 REF#: 7681026702471

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/Discount	Deduct/Copay Amount	Coinsurance Amount	DRG/Per Diem/APC Type	DRG/Per Diem/APC Number	DRG/Per Diem Amount	DRG/Per Diem Benefit Amount	Plan Benefit	See Note
1	09172018	22551		50400.00			50400.00					0.00	0.00	0.00	A0
2	09172018	22853		10000.00			10000.00					0.00	0.00	0.00	A1
3	09172018	20939		480.00			480.00					0.00	0.00	0.00	A1
	TOTAL			60880.00			60880.00							0.00	

BALANCE.................... $50,400.00

** NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

DHC-ASH

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) BENEFITS WERE REDUCED OR DENIED BECAUSE PRE-ADMISSION REVIEW GUIDELINES WERE NOT FOLLOWED.
A1) THIS PROCEDURE CODE IS DISALLOWED BECAUSE THE RELATED PRIMARY SERVICE HAS EITHER NOT BILLED OR DENIED.

9-27-70

Call

671951 Job #

A0 - Pre auth obtained on 5-25-18 - Date of service changed to 9-17-18 - that was updated w/ Cigna on 6/26/18

A1 - Primary procedure is 22551

G2433C 04-08-2016 PROCLAIM Provider Checkless EOP Summary

12-6-18
S/w Cigna

ref # 9704
Ariel (man)
2-3 bus days calling back

1/10/19 Faxed to Vanessa

12/19/18 - S/w Vanessa says new auth only for 22845

ref #2609

Fax # 1866-434-1944 Vanessa (Cigna)
Auth Letter Sent

12/19/18 requested taped conversation on 6/26/18
Cigna.com - link forms / Cignahealthcare / privacy forms,
12/19/18 sent forms to pt to sign - notarize

Alstano-

Provider Explanation of Medical Benefits Report

Cigna.

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
222478733 0023	METROPOLITAN NEUROSURGER	11/23/2018		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
1	09172018	22551		10800.00			10800.00						0.00	0.00	A0
2	09172018	22853		2000.00			2000.00						0.00	0.00	A1
	TOTAL			12800.00			12800.00							0.00	

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

PATIENT NAME: GREGG M[redacted]
PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER
SUBSCRIBER NAME: GREGG M[redacted]

PATIENT#: C8900072
PROVIDER NETWORK STATUS: OUT OF NETWORK
SUBSCRIBER#: U47897017

OPERATION LOCATION/GROUP# 53496-9-3336654 RECEIVE DATE: 09/24/2018 PROCESS DATE: 11/23
REF#: 7681826891465

BALANCE..... $10,800.00

** NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

PRD-AKU
VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) BENEFITS WERE REDUCED OR DENIED BECAUSE PRE-ADMISSION REVIEW GUIDELINES WERE NOT FOLLOWED.
A1) THIS PROCEDURE CODE IS DISALLOWED BECAUSE THE RELATED PRIMARY SERVICE WAS EITHER NOT BILLED OR DENIED.

3417201833O2

EXHIBIT “D”

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CIGNA HEALTHCARE
PO BOX 182223
CHATTANOOGA TN 37422

CARRIER

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): U47897017 01

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted], GREGG

3. PATIENT'S BIRTH DATE MM DD YY SEX: [redacted] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted], GREGG

[redacted]

PATIENT AND INSURED INFORMATION

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? X YES NO PLACE (State): NJ

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA HEALTHCARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: PLYMOUTH ROCK MEDICAL CLAIMS

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 05/24/2018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 27 2017 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 11 27 2017

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 09 17 2018 TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M50322 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: IP0184100726

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EFSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	17	2018	09	17	2018	21		22551	82	A	10800 00	1		NPI	222478733 1407971542
2	09	17	2018	09	17	2018	21		22853	82	A	2000 00	1		NPI	222478733 1407971542
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 222478733 X

26. PATIENT'S ACCOUNT NO.: C8900072

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 12800 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

KEVIN C YAO, MD
SIGNED 04/23/2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ENGLEWOOD HOSPITAL & MEDIC
350 ENGLE STREET
ENGLEWOOD NJ 07631-1808
a. 1083612881 b.

33. BILLING PROVIDER INFO & PH # (201) 5697737
METROPOLITAN NEUROSURGERY ASS
309 ENGLE STREET
ENGLEWOOD NJ 07631-1822
a. 1881661403 b. G2222478733

CIGNA HEALTHCARE
PO BOX 182223
CHATTANOOGA TN 37422

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): U47897017 01

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted], GREGG

3. PATIENT'S BIRTH DATE [redacted] SEX: X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] GREGG

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

X YES NO NJ

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA HEALTHCARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: PLYMOUTH ROCK MEDICAL CLAIMS

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 05/24/2018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 27 2017 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 11 27 2017

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 09 17 2018 TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M50322 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: IP0184100726

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09172018	09172018	21		22551		A	50400 00	1		NPI	222478733 1548429038
2 09172018	09172018	21		22853		A	10000 00	1		NPI	222478733 1548429038
3 09172018	09172018	21		20939		A	480 00	1		NPI	222478733 1548429038
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 222478733 SSN EIN X

26. PATIENT'S ACCOUNT NO.: C8900071

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 60880 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
YAKOV GOLOGORSKY MD
SIGNED 04/23/2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ENGLEWOOD HOSPITAL & MEDIC
350 ENGLE STREET
ENGLEWOOD NJ 07631-1808
a. 1083612881 b.

33. BILLING PROVIDER INFO & PH # (201) 5697737
METROPOLITAN NEUROSURGERY ASS
309 ENGLE STREET
ENGLEWOOD NJ 07631-1822
a. 1881661403 b. G2222478733

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT “E”

METROPOLITAN NEUROSURGERY ASSOCIATES, P.A.

Diplomates American Board of Neurological Surgery

A. A. STEINBERGER, M.D., FAANS
FRANK M. MOORE, M.D., FAANS
MARC S. ARGINTEANU, M.D., FAANS
KEVIN C. YAO, M.D., FAANS
YAKOV GOLOGORSKY, M.D., FAANS
OMAR N. SYED, M.D., FAANS

January 10, 2019

ATTN: Vanessa
Fax: 1866-434-1944

Cigna Health Care
P.O. Box 182223
Chattanooga TN 37422-7223

ATT: Appeals Department

RE: [redacted], **GREG**
ID No.: U47897017
Date of Service: September 17, 2018
Claim Amounts: $60,880.00 & $12,800.00

To Whom It May Concern:

The purpose of this letter is to address the unpaid claims on the above named patient for September 17, 2018. We have received an Explanation of Benefits on this patient and you have denial codes of A0 and A1. They deny the primary procedure stating benefits were reduced or denied because pre-admission review guidelines were not followed and then you denied the rest of the procedure stating that the procedure code is disallowed because the related primary procedure was either not billed or denied.

This patient was originally scheduled for surgery on August 13, 2018. Enclosed you will find your authorization letter to the patient dated May 25, 2018 that the procedures are approved. It says approved insertion of spinal fixation device 22551, 22853, 20939 and in parentheses 22845. The date of service for this surgery got re-scheduled and on June 26, 2018 we spoke with your representative by the name of Rich E to change the date of service to September 17, 2018. We did not change any procedure codes or the procedure. The only thing we changed was the date of service. Your representative told us that now the new authorization number that Rich gave us IP0184100726 is only for CPT Code 22845. That is incorrect because we never changed the procedure. We only changed the date of service. The procedure from the original authorization still stands.

Date: 01/10/2019
Re: GREG [redacted]

Enclosed you will also find a letter signed by the patient and notarized the request for access to protected health information and on this letter it is asking for a copy of the phone call dated June 26, 2018 where our office spoke with Rich E and he is the one that voided out the first authorization instead of just changing the date of service.

Again it was only the date of service that changed, not any procedure codes.

We would like someone to look into this and look into that phone call and listen to that phone call that we had with that representative along with sending us a copy showing that this claim for Mr. Masse is getting denied erroneously. Unfortunately due to your company's denial, Mr. Masse's claim will be forwarding to a collection agency. We are also sending Mr. Masse a copy of this letter, a copy of all our documentation, and advising him that he would need to take it up further with Cigna and if necessary the Department of Insurance and an attorney.

Awaiting your written reply and the copy of the conversation.

Sincerely,

P. Kreush, R.N.
Billing Manager

PK/dp
Dictated, but not read

1640 DALLAS PARKWAY
PLANO TX 75093

Cigna®

May 25, 2018

Telephone: 800.244.6224
www.CIGNA.com

GREGG [redacted]

Re: Customer: GREGG [redacted]
Customer ID #: U47897017 01
Reference Code: B5C31MK1
Cigna Health Management, Inc*, on behalf of Cigna Health and Life Insurance Company
Authorization Effective Date(s): 08/13/2018 to 08/15/2018
Total Approved Day(s): 2
Bed Type: Medical/Surgical
Next Review Date: 08/14/2018

Dear GREGG [redacted]:

Your health plan requires some services to be reviewed and approved for coverage before you receive them. On 05/25/2018, YAKOV GOLOGORSKY, MD asked us to review and approve the following service(s):

- Approved: Insertion of Spinal Fixation Device 22551 22853 20939 (22845)

After reviewing your medical information and health plan, we approved this request.

Important reminders:

- When we receive your medical claim(s), we'll need to make sure your health care professionals performed only services we approved. If extra services were performed that weren't medically necessary or covered by your plan, we won't be able to pay for them.
- This letter isn't a guarantee that your plan will pay for the services. You must be enrolled in the plan and eligible for benefits on the date you receive the service. Please see your plan documents for details about your coverage. You're responsible for your share of any copayments, coinsurance, or other costs.

While you're in the hospital, we'll work with your doctors and other health care professionals to get approvals for any medically necessary services covered by your plan. After you leave the hospital, you and your doctor are responsible for getting approvals for additional medical services.

You and your health care professional can view the Cigna Medical Necessity Guidelines anytime on Cigna.com .

If you have any questions, please call Customer Service at the toll-free number on your ID card. An associate is available to help you 24 hours a day, 7 days a week.

We look forward to helping you in any way we can.

If you have a hearing or speech impairment and use Telecommunications Relay Services (TRS) or a Text Telephone (TTY), dial 711 to connect with a TRS operator.

Sincerely,

JOSE MURILLO DELA CRUZ IV

JOSE MURILLO DELA CRUZ IV
Clinical Service Associate

c: ENGLEWOOD HOSPITAL AND MEDICAL CENTER
YAKOV GOLOGORSKY, MD

EXHIBIT “F”

METROPOLITAN NEUROSURGERY

PRECERTIFICATION FORM

Patients Name: Gregg [redacted]

Primary Ins: Cigna- U 4789 7017 01

Secondary Ins: Plymouth Rock 0466 01544 666

Date of Surgery: 9-17-18

Place of Surgery: Englewood Hospital

Primary Surgeon: Dr. Gologerosky

Asst/Co-Surgeon: Dr. Yao

Diagnosis: Disc herniation

Diagnosis code: M50.222

Procedure: C5-6 ACDFI

Procedure code: 22551, 22845, 22853 20939

Pre-cert phone: Cigna 1-800-548-3980 / Plymouth Rock 732-378-4533

Person authorizing sx: Joe D. from Cigna 5-25-18

Reference #:

Authorization #: IP0184100726 approved w/ one night.

5-25-18 S/W Marina Berman from Plymouth Rock they do not require auth when they are secondary.

6-26-18 S/W Rich E. to change DOS 9-17-18
new auth # IP0184100726

EXHIBIT “G”

METROPOLITAN NEUROSURGERY
*Diplomate American Board of Neurological Surgery

A.A. STEINBERGER, M.D., F.A.A.N.S
FRANK M. MOORE, M.D., F.A.A.N.S
MARC. S. ARGINTEANU, M.D., F.A.A.N.S
KEVIN C. YAO, M.D., F.A.A.N.S
YAKOV GOLOGORSKY, M.D., F.A.A.N.S
OMAR N. SYED, M.D., F.A.A.N.S

ASSIGNMENT OF BENEFITS

Patient Name: Gregg Masse

I irrevocably assign to Metropolitan Neurosurgery Associates, P.A. (MNA), all of my rights and benefits under any insurance contracts for payment for services rendered to me by MNA. I irrevocably authorize all information regarding my benefits under my insurance policy relating to any claim by MNA to be released to MNA. I irrevocably authorize MNA to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to MNA. I irrevocably authorize MNA to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize MNA to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, if said sums are not paid within the legally prescribed period. In the event that MNA elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I irrevocably assign my rights, title and interest under the medical expense benefits and/or pip section of any insurance policy under which I am entitled to precede for benefits. This assignment shall allow an attorney of MNA choosing to bring suit or submit for arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize MNA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP beenfits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of MNA.

This undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to MNA upon receipt of the same.

A photocopy of this assignment shall be valid as the original.. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

[redacted]
Patient Signature

5/18/2020
Date

309 Engle Street, Englewood, NJ 07631
Telephone (201) 569-7737
Fax (201) 373-2041

Our physicians are Medicare Participating providers (not including Dr. Arginteanu). We will bill Medicare directly and accept assignment. Medicare will pay 80% of the Medicare allowed charges and you, the patient, are responsible for 20%. You are also responsible for your annual deductible and any non-covered service. We will submit all claims to all insurance carriers as long as you provide our office with your current/ correct insurance information. We do not participate with insurance plans aside from Medicare and the current list posted in our office. You the insured are responsible for deductible and co-ins. portions not covered by your plan. **We can treat any patient whose plan has out of network benefits.**

Lifetime Insurance Signature Form

I request payment of insurance benefits, (Ii.e. Medicare, commercial, PIP, worker's comp., or any type of policy I am covered under), be made directly to the provider of services Metropolitan Neurosurgery Associates, PA, (herein referred as MNA) and affiliated physicians on my behalf. I authorize release of any medical information necessary to process an insurance claim or determine benefits. Patients sent here specifically for IME's are not responsible for any payment.

I hereby authorize MNA to release any information acquired in the course of my treatment and examination. I hereby assign to MNA all money to which I am entitled, for medical or surgical expenses and services provided by any of their affiliated doctors (Drs. Steinberger/Moore/Yao/Gologorsky/Syed). I agree to forward any payment made to me by insurance for services rendered by MNA directly to their office upon receipt of such payment made to me by insurance for services rendered by MNA directly to their office upon receipt of such payment with the EOB attached. I understand that any insurance money paid to me for services rendered by MNS and not forwarded to same to satisfy payment for services rendered will be pursued according to law.

I understand that I am responsible to follow up with my insurance for payment for services provided to assure timely payment. Any charges over 90 days are subject to collections by an outside agency or attorney. I agree to pay all costs involved with collection procedures. Further, I understand that I am entering into a contractual relationship with MNA for professional care. I further understand that meritless and frivolous claims for medical malpractice and an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider.

As an additional consideration for professional care provided to me by MNA, i the undersigned patient and /or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Metropolitan Neurosurgery Associates, PA.

Furthermore, should a meritorious medical malpractice case or case of action be initiated or pursued. I, the patient and /or my representative agree to use the EBNS board-certified expert medical witness(es) in the same or similar specialty as our physicians. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/ or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such case. In further consideration for this, we the physicians in MNS, agree to the same stipulations.

I certify that I have read this document, agree to its content and that all information stated is true and correct to the best extent of my knowledge. This contract is effective from the date of first service.

[redacted]

Signature of patient or authorized representative

Date: 5/18/2020

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Metropolitan Neurosurgery Associates (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Metropolitan Neurosurgery Associates for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers, or any other person or business that provides healthcare activity services as a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended ("ERISA") and any applicable State Law. Each Authorized Representative is granted the same rights which I have

as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independant dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with the claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined byt the Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: Gregg [redacted] Date: 5/18/2020

Patient Signature: [redacted]

Court's Address and Phone Number:
BERGEN Special Civil Part
10 MAIN STREET, ROOM 415
HACKENSACK, NJ 07601-0000
201-221-0700 ext.25250

Superior Court of New Jersey
Law Division, Special Civil Part
BERGEN County
Docket No: **BER-DC-002520-24**

Civil Action
CONTRACT DISPUTE

YOU ARE BEING SUED!

Person or Business Suing You (*Plaintiff*)
Metropolitan Neurosurgery Associates on assignment of Gregg M.

Plaintiff's Attorney Information
LORI B SHLIONSKY
CALLAGY LAW
650 FROM RD STE 240
PARAMUS, NJ 07652-0000
201-261-1700

Person or Business Being Sued (*Defendant*)
Cigna Health and Life Insurance Company

The Person or Business Suing You Claims You Owe the Following:

Demand Amount	$13404.75
Filing Fee	$75.00
Service Fee	$7.00
Attorney's Fees	$0.00
TOTAL	**$13486.75**

FOR JUDICIARY USE ONLY

In the attached complaint, the person or business suing you briefly tells the court his or her version of the facts of the case and how much money he or she claims you owe. **If you do not answer the complaint, you may lose the case automatically and the court may give the plaintiff what the plaintiff is asking for, plus interest and court costs. You have 35 days from the date of service to file your answer or a signed agreement.** If a judgment is entered against you, a Special Civil Part Officer may seize your money, wages or personal property to pay all or part of the judgment. The judgment is valid for 20 years.

IF YOU DISAGREE WITH THE PLAINTIFF'S CLAIMS, A WRITTEN ANSWER OR SIGNED AGREEMENT MUST BE RECEIVED BY THE COURT ABOVE, ON OR BEFORE 03/25/2024, OR THE COURT MAY RULE AGAINST YOU. IF YOU DISAGREE WITH THE PLAINTIFF, YOU MUST DO ONE OR BOTH OF THE FOLLOWING:

1. ***Answer the complaint***. An answer form that will explain how to respond to the complaint is available at any of the New Jersey Special Civil Part Offices or on the Judiciary's Internet site njcourts.gov under the section for Forms. If you decide to file an answer to the complaint made against you:
   - Fill out the Answer form AND pay the applicable filing fee by check or money order payable to: ***Treasurer, State of New Jersey***. Include **BER-DC-002520-24** (your Docket Number) on the check.
   - Mail or hand deliver the completed Answer form and the check or money order to the court's address listed above.
   - Hand deliver or send by regular mail a copy of the completed Answer form to the plaintiff's attorney. If the plaintiff does not have an attorney, send your completed answer form to the plaintiff by regular and certified mail. This MUST be done at the same time you file your Answer with the court on or before **03/25/2024**.
2. ***Resolve the dispute.*** Contact the plaintiff's attorney, or contact the plaintiff if the plaintiff does not have an attorney, to resolve this dispute. The plaintiff may agree to accept payment arrangements. If you reach an agreement, mail or hand deliver the **SIGNED** agreement to the court's address listed above on or before **03/25/2024**.

Please Note - You may wish to get an attorney to represent you. If you cannot afford to pay for an attorney, free legal advice may be available by contacting Legal Services at 201-487-2166. If you can afford to pay an attorney but do not know one, you may call the Lawyer Referral Services of your local County Bar Association at 201-488-0044. Notify the court now if you need an interpreter or an accommodation for a disability for any future court appearance.

/s/ Michelle M. Smith
Clerk of the Superior Court

Dirección y teléfono del tribunal Parte Civil Especial de BERGEN 10 MAIN STREET, ROOM 415 HACKENSACK, NJ 07601-0000 201-221-0700 ext.25250	**El Tribunal Superior de Nueva Jersey** **División de Derecho, Parte Civil Especial** Condado de **BERGEN** Número del expediente **BER-DC-002520-24** **Demanda de Acción Civil** **NOTIFICACIÓN DE DEMANDA** **CONTRACT DISPUTE**

¡LE ESTÁN DEMANDANDO!

Persona o entidad comercial que le está demandando *(el demandante)*
Metropolitan Neurosurgery Associates on assignment of Gregg M.

Información sobre el abogado del demandante
LORI B SHLIONSKY
CALLAGY LAW
650 FROM RD STE 240
PARAMUS, NJ 07652-0000
201-261-1700

Persona o comercial ser demandada *(el demandado)*
Cigna Health and Life Insurance Company

La persona o comercial que le está demandando afirma que usted le debe lo siguiente:

Cantidad a la vista	$13404.75
Tasa judicial	$75.00
Cargo del emplazamiento	$7.00
Honorarios del abogado	$0.00
TOTAL	**$13486.75**

PARA USO EXCLUSIVO DEL PODER JUDICIAL

En la demanda adjunta la persona o entidad comercial que le está demandando le informa brevemente al juez su versión de los hechos de la causa y la suma de dinero que afirma que usted le debe. **Si usted no responde a la demanda puede perder la causa automáticamente y el juez puede dar al demandante lo que está pidiendo más intereses y los costos legales. Usted tiene 35 días a partir de la fecha del emplazamiento para presentar su respuesta o un acuerdo firmado.** Si se dicta un fallo en su contra, un Oficial de la Parte Civil Especial puede embargar su dinero, sueldo o sus bienes muebles (personales) para pagar todo el fallo o una parte del mismo. El fallo es válido por 20 años.

SI USTED NO ESTÁ DE ACUERDO CON LAS ALEGACIONES DEL DEMANDANTE, EL TRIBUNAL TIENE QUE RECIBIR UNA RESPUESTA POR ESCRITO O UN ACUERDO FIRMADO PARA EL 03/25/2024 O ANTES DE ESA FECHA, O EL JUEZ PUEDE EMITIR UN FALLO EN SU CONTRA. SI USTED NO ESTÁ DE ACUERDO CON EL DEMANDANTE, DEBE HACER UNA DE LAS SIGUIENTES COSAS O LAS DOS:

1. ***Responder a la demanda***. Un formulario de respuesta que le explicará cómo responder a la demanda está disponible en cualquiera de las Oficinas de la Parte Civil Especial de Nueva Jersey o en el sitio Internet del Poder Judicial njcourts.gov bajo la sección de formularios (Forms). Si usted decide presentar una respuesta a la demanda que se hizo en su contra:
   - Llene el formulario de Respuesta Y pague la tasa judicial de presentación que corresponda mediante un cheque o giro bancario o postal acreditable al: "***Treasurer, State of New Jersey*** " (Tesorero del Estado de Nueva Jersey). Incluya **BER-DC-002520-24** (el número de su expediente) en el cheque.
   - Envíe por correo el formulario de Repuesta llenado y el cheque o giro bancario o postal a la dirección del tribunal que figura más arriba, o entréguelos personalmente en dicha dirección.
   - Entregue personalmente o envíe por correo común una copia del formulario de Repuesta llenado al abogado del demandante. Si el demandante no tiene abogado, envíe su formulario de respuesta llenado al demandante por correo común y por correo certificado. Esto SE TIENE que hacer al mismo tiempo que presente su Respuesta al tribunal a más tardar el **03/25/2024.**
2. ***Resolver la disputa.*** Comuníquese con el abogado del demandante, o con el demandante si éste no tiene abogado, para resolver esta disputa. El demandante puede estar de acuerdo con aceptar arreglos de pago. **Si llegara a un acuerdo, envíe por correo o entregar personalmente el acuerdo FIRMADO** a la dirección del tribunal que figura más arriba, o entréguelo personalmente en dicha dirección a más tardar el **03/25/2024**.

Nota - Puede que usted quiera conseguir que un abogado para que lo represente. Si usted no puede pagar a un abogado, podría obtener consejos legales gratuitos si se comunica con Legal Services (Servicios Legales) llamando al 201-487-2166. Si usted puede pagar a un abogado, pero no conoce a ninguno, puede llamar al Lawyer Referral Services (Servicios de Recomendación de Abogados) del Colegio de Abogados (Bar Association) de su condado local al 201-488-0044. Notifique al tribunal ahora si usted necesita un intérprete o un arreglo por una discapacidad para cualquier comparecencia futura en el tribunal.

/s/ Michelle M. Smith
Subsecretario(a) del Tribunal Superior

BERGEN SPECIAL CIVIL PART
BERGEN COUNTY COURTHOUSE
BERGEN COUNTY JUSTICE CENTER
HACKENSACK NJ 07601-7680
TELEPHONE: (201) 221-0700

LORI B SHLIONSKY
CALLAGY LAW
650 FROM RD
STE 240
PARAMUS NJ 07652

FEBRUARY 08, 2024

CV0210

CASE NUMBER: BER DC-002520-24
METROPOLITAN NEUROSU
VS
CIGNA HEALTH AND LIF E IN

A SUMMONS WAS MAILED TO DEFENDANT(S) ON 02-12-24 FOR CASE DC-002520-24. UNLESS OTHERWISE NOTIFIED, THIS CASE WILL DEFAULT ON 03-25-2024.